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STATEMENT OF

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SUBCOMMITTEES ON MILITARY PERSONNEL AND READINESS
OF THE
HOUSE ARMED SERVICES COMMITTEE

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Chairman Ortiz, Congressman Forbes, and distinguished members of the Subcommittee, I appreciate the opportunity today to appear before to discuss the Department's Military Construction (MILCON) and BRAC programs as each relates to the Department's medical facilities.

Overview

As we have testified in the past, our installations are the foundation of America's security – these assets must be available when and where needed, with the capabilities to support current and future mission requirements. As the enterprise managers of the defense installations portfolio, the Office of the Deputy Under Secretary of Defense (Installations and Environment) is a focal point in ensuring their capabilities are delivered effectively and efficiently in support of our operations. Our role in supporting medical facilities is the same as that for all other facilities – we focus on fostering the best management practices to ensure the facilities are available when and where needed. As such, we are the advocates for ensuring the facilities receive the investment necessary for their continued operation. In carrying out our responsibilities as they relate to medical facilities, we work closely with the Assistant Secretary of Defense (Health Affairs) and the Tricare Management Activity (TMA). Since the establishment of TMA in 1998, our office has worked with the Military Departments, their Surgeons General, and TMA to prioritize operational and facility requirements, and develop programming plans necessary to implement their priorities.

Currently, our extensive inventory of medical facilities has an estimated plant replacement value (PRV) of approximately $20 billion. While most of the medical facilities are hospitals, there are also medical and dental clinics and supporting facilities like medical research, training facilities, warehouses and ambulance shelters. All of these facilities are essential to the provision of quality medical care throughout the Department. In our role as advocates for all facilities, we focus on the same areas of investment for medical facilities as for all other facility types in DoD's inventory. The investment that we make in our facilities is essential to the optimal performance of those facilities throughout their lifecycle.

Managing Infrastructure

The Deputy Under Secretary of Defense (Installations and Environment) oversees the acquisition, maintenance and recapitalization of all facilities, is responsible for related policy and advocacy within the Department's programming and budgeting process. The overarching goal is to continually improve the quality of military installations. Managing DoD real property assets is integral to achieving the appropriate level of quality.

First and most important, we are focused on our investment in facilities sustainment which supports the regularly scheduled maintenance and repair that is required to keep the facilities in good working order. Providing sufficient funding for maintenance and repair is critical to preventing premature deterioration of the facilities. Recognizing the need for renewed emphasis on facilities sustainment, the Department has

issued guidance that directs funding for facilities sustainment at no less than 90% of the requirement generated by the Facilities Sustainment Model (FSM). FSM estimates the resources needed to perform the regularly scheduled maintenance required to keep facilities in good working order. It includes periodic repair or replacement of facility components such as roofing, HVAC systems, plumbing and electrical systems, and fire protection throughout the life cycle of facilities. As is true of all facilities, funding at a minimum of 90% of the sustainment requirement will also reduce the risk of premature deterioration of our medical facilities. Medical facilities are funded at 93% in the FY 2009 President's Budget.

In addition to facilities sustainment, we're also very concerned about the recapitalization of medical facilities so that they remain mission ready and are modernized on a schedule that prevents obsolescence. Mission readiness and modernization require investments in facilities beyond the regularly scheduled maintenance and repair. We're in the process of refining our methodology for determining the appropriate level of investment, and in part, that will be determined by the Condition Index of a given facility.

The Condition Index is a general measure of the constructed asset's condition at a specific point in time, and one measure of the impact that facility funding has on the quality of facilities. It is calculated as a function of the resources needed to restore a facility to a condition equivalent to its originally designed capacity or capability,

compared to its PRV. Within DoD, the Condition Index is referred to as the "Quality Rating" (Q-Rating), and is expressed on a scale of one to four with one being in good condition, and four being in failing condition. Our long-term goal is to focus our recapitalization investment to eliminate all facilities that are rated as Q-3 or Q-4 either by addressing the shortcomings of each facility or demolishing and replacing them if restoring and modernizing them is not economically feasible. For medical facilities, given the requirement for accreditation, the Service medical departments base their facility condition ratings on more detailed engineering assessments that provide a comprehensive picture of the condition of the medical facility portfolio.

Our focus on the effectiveness of our recapitalization effort is of particular importance for medical facilities. In the past, methodologies used to determine the right level of investment proved to be problematic for accurately evaluating or forecasting the resources needed to keep our medical facilities current with the latest advancements in medicine and approaches to overall patient care. We have recognized for some time that our medical facilities need to be modernized on a much shorter timeline, and that the guidelines that applied to other types of facilities are not sufficient for medical facilities. We're continuing to refine and evolve the manner in which we determine the appropriate level of funding to recapitalize our inventory, and will continue to be mindful of the distinct requirements for medical facilities.

Ongoing Initiatives

Within the Department, it has been and continues to be our goal to provide the right quality facilities in the right locations in the most cost-effective manner. One example of how we're accomplishing that in our medical facilities is through the collaborative effort that we've undertaken with the Veteran's Administration. By combining medical facilities where practicable, we can best serve the entire eligible population with consistent care for all. That approach is well underway at the Navy's Great Lakes Training Center, and we believe that the consolidation of the Great Lakes North Chicago Hospital project at the Chicago Veteran's Administration Medical Center will pay great dividends in the long term. The federal health care facility that consolidates all North Chicago and Great Lakes health care resources is an 8-year, 3-phased approach which began in 2002 and will see the activation of phase III in the fall of 2010.

In addition to specific undertakings with the Veteran's Administration, we continue to pursue a robust military construction program for medical facilities. The FY07, 08, and 09 budgets included over $620 million for hospitals, medical research facilities, medical training facilities, primary care clinics, dental clinics, women's health services facilities, and supporting facilities such as a utility plant and a parking structure. The majority of these improvements and additions are being made at our installations within the continental US.

Rationalizing and Recapitalizing Medical Infrastructure through Base Realignment and Closure (BRAC) 2005

BRAC 2005 is the largest round of base closures and realignments undertaken by the Department and the first one to review comprehensively the Department's medical infrastructure. After an exhaustive examination of over 1,200 alternatives, the Secretary of Defense forwarded 222 recommendations to the BRAC Commission for its review. The Commission accepted about 65 percent without change and its resulting recommendations were approved by the President and forwarded to the Congress. The Congress expressed its support of these recommendations by not enacting a joint resolution of disapproval by November 9, 2005; therefore, the Department became legally obligated to close and realign all installations so recommended by the Commission in its report. A key component of this BRAC round was rationalizing Medical infrastructure. This rationalization is needed to address the transformation in healthcare that has occurred since these facilities were constructed and to adapt our facilities to address the continuing changes in warrior care. At one end of the scale, BRAC enabled the Department to close seven small and inefficient inpatient operations, converting them to ambulatory surgery centers. BRAC also enabled DoD to realign medical operations from McChord Air Force Base to Ft Lewis and transform the Medical Center at Keesler, Air Force Base into a community hospital. On the larger end of the scale, BRAC enabled DoD to realign two of its major military medical markets: San Antonio and the National Capital Region. The strategic realignments in San Antonio and the National Capital Region address a critical need to realign and consolidate key clinical

and clinical research capabilities while addressing serious facility modernization requirements. These transformations, requiring facility closures as well as restructuring, could not have bee accomplished holistically or efficiently without the authority provided by the BRAC process.

In San Antonio, DoD is consolidating in-patient services into a recapitalized Brooke Army Medical Center while facilitating DoD's goal of replacing the aging Wilford Hall medical center with state-of-the art ambulatory outpatient center. The BRAC analysis correctly determined that the San Antonio healthcare requirements would be best served with a single medical center and a large ambulatory care center (at Wilford Hall) that allows for focused facilities that will provide the best possible care for the foreseeable future.

We are working similarly in the National Capital Region. BRAC allowed DoD to close Walter Reed and transfer its services to both an expanded Bethesda and the new community hospital at Ft. Belvoir. In addition, the medical center at Andrews Air Force Base will be transformed into a clinic by the closure of the inpatient wards. This allows DoD to forgo the cost of renovating the aging Walter Reed facility and instead focus its resources to re-align the active duty beneficiaries to the remaining hospitals in line with their demographics. The BRAC recommendation correctly recognized that renovation of the Walter Reed Army Medical Center was not the optimum application of our resources due to its age (and doing so would significantly degrade the availability of the healthcare

needs across the NCR). As such, through BRAC we were able to address long-standing health needs regarding the need to better match facility locations and capabilities, medical advances, and changing wounded warrior needs.

After BRAC, the National Capital Region will host two premier facilities that will provide the best possible care while being a center of research and training of health care professionals. For the National Capital Region, the FY 09 costs (including those born in the FY 2009 supplemental) are $2.0B. As is the case with San Antonio, costs rose due to construction inflation, wounded warrior lessons learned, and unforeseen costs as the construction process has unfolded.

Unique to the National Capital Region is the effort to enhance and accelerate construction at Bethesda and Ft. Belvoir as result of lessons learned and the Department's commitment to implement the recommendations of the *Independent Review Group (IRG) on Rehabilitative Care and Administrative Processes at Walter Reed Army Medical Center and National Naval Medical Center* (Co-Chaired by former Secretary of the Army Secretary Togo West and former Secretary of the Army and Congressman Jack Marsh). The IRG's April 2007 report recommended a variety of measures to improve medical care and recommended that DoD accelerate BRAC projects in the National Capital Region (NCR). In order to implement the report's recommendations and incorporate other war-related lessons learned, the Department committed to create Warrior Transition Unit facilities at the Bethesda Campus to enhance wounded warrior care, especially the

outpatient convalescent phase. The Department also committed to enhance the inpatient facilities at both Belvoir and Bethesda. These enhancements together with a commitment to accelerate construction to ensure that the new facilities will be operational as soon as possible, required the investment of an additional $679M. The FY 2008 supplemental appropriated $416M. As noted in the justification material submitted with the FY09 President's Budget, "DoD intends to seek additional funding of $263.3 million" for the balance of funding. These enhancements and other cost increases (construction inflation and scope increases) would bring the total of the investment to $2.0B as of the FY 09 President Budget (including the $263M).

Also unique to the National Capital Region is the Department's decision to place the control of the facilities and the management of BRAC into the hands of a Joint Task Force Capital Medicine headed by VADM John Mateczun. This decision enables unity of command and fosters the development of joint management of the hospitals. This not only ensures that each Military Department will benefit from modernized facilities being constructed, but this also mirrors the joint nature that infuses military medical support to military operations around the world.

One other medical-related BRAC issue is significant. The Department is proceeding to implement the Commission's recommendation to co-locate a Combined Medical Headquarters within the National Capital Region. Besides realigning these HQs into a proximate location, this recommendation requires consolidation of support

functions which will further jointness and efficiency. Co-location will enable Health Affairs, the TRICARE Management Activity, and the Service Surgeons General to function even more as a unified team. More detail on how this will occur will unfold as the Department and the General Services Agency work together to solicit competitive bids for a leased location.

Conclusion

In closing, Mr. Chairman, I sincerely thank you for this opportunity to highlight the Department's efforts regarding Military Medical facilities, the medical MILCON program, and BRAC. Just as our military must be flexible and responsive, our installations must also adapt, reconfigure, and be managed to maximize that flexibility and responsiveness. We appreciate your continued support and we look forward to working with you as we continue to transform our medical infrastructure.